Suicide In the Elderly
Risk Factors
&
Beginning Steps

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"To most of those who have experienced it, the horror of depression is so overwhelming as to be quite beyond expression. . . if depression had no termination, then suicide would, indeed, be the only remedy. But. . . depression is not the soul's annihilation; men and women who have recovered from the disease-and they are countless-bear witness to what is probably its only saving grace: it is conquerable."
--William Styron

Myths

If someone's determined to kill themselves, no one can stop them.

Those who complete suicide do not seek help before their attempt.

Myths

Those who kill themselves must be crazy.

Asking someone about suicide can lead to suicide.

Myths

Pain goes along with aging so nothing can be done.

It makes sense for an old person to want to end their suffering.

Myths

Old people are used to death and loss and don't feel them like younger folks.

Those who talk about suicide rarely actually do it.

General Statistics re: Suicide

Mortality

- **All suicides** Number of deaths: 31,655
  Deaths per 100,000 population: 11.0
- **Firearm suicides** Number of deaths: 17,108
  Deaths per 100,000 population: 5.9
- **Suffocation suicides** Number of deaths: 6,462
  Deaths per 100,000 population: 2.2
- **Poisoning suicides** Number of deaths: 5,489
  Deaths per 100,000 population: 1.9

http://www.cdc.gov/nchs/fastats/suicide.htm

Facts about Suicide in the Elderly

Facts

- Elderly accounted for 13% of population in US, but 18% of all suicides in 2000
- Suicides are highest among those >65
- White males (>85), 5 times more death
- 1 in 4 suicide completions; for every completed suicide, there may have been 8-25 attempts
- 80% of those who threaten suicide, eventually do it

1999 - 2002, United States
Suicide Injury Deaths and Rates per 100,000
All Races, Both Sexes, Ages 65 to 85+

Year	Number of Deaths	Population	Crude Rate
1999	5,489	34,797,847	15.77
2000	5,306	34,991,753	15.16
2001	5,393	35,337,728	15.26
2002	5,548	35,607,547	15.58
Total	**21,736**	**140,734,875**	**15.44**

CDC data

1999 - 2002, New Hampshire
Suicide Injury Deaths and Rates per 100,000
All Races, Both Sexes, Ages 65 to 85+

Year	Number of Deaths	Population	Crude Rate
1999	22	146,609	15.01
2000	20	147,970	13.52
2001	18	150,215	11.98
2002	20	152,107	13.15
Total	**80**	**596,901**	**13.40**

CDC data

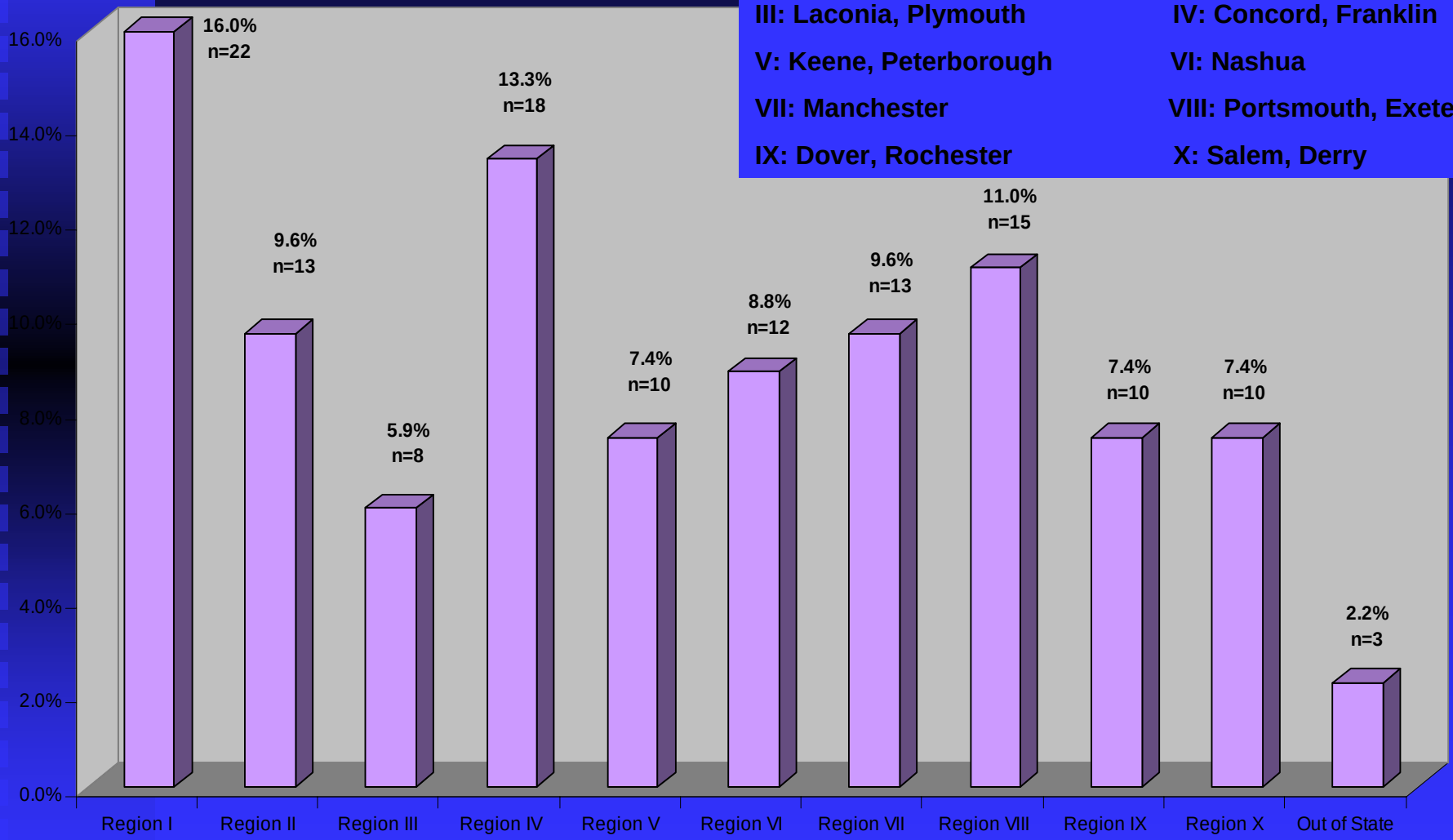
Suicide in New Hampshire
Data from the NH Office of the Chief Medical Examiner

- 217 Known suicides of people age 50+ between 1/1/2001 and 3/23/2006
- Since 11/1/2005, 18 suicides of people age 50+ (from a total of 46 suicides in the State)
- In the first 3 weeks of March 2006 alone, 4 of 7 suicides were from this age group
- 62.5% Used firearms
- 5.8% Had been using alcohol and/or drugs at time of death

E. Fenner-Lukaitis, LICSW, Div Community Based Care Services, Bureau of Behavioral Health, 3/23/06

Suicide in New Hampshire
Data from the NH Office of the Chief Medical Examiner

I: Littleton, Conway, Wolfeboro	II: Lebanon, Claremont
III: Laconia, Plymouth	IV: Concord, Franklin
V: Keene, Peterborough	VI: Nashua
VII: Manchester	VIII: Portsmouth, Exeter
IX: Dover, Rochester	X: Salem, Derry



E. Fenner-Lukaitis, LICSW, Div Community Based Care Services, Bureau of Behavioral Health, 3/23/06

N=135, info was not initially available

Suicide in New Hampshire
Data from the NH Office of the Chief Medical Examiner

- 84.5% male; 15.4% female
- Almost 50% were accounted for in those in their 5th decade of life; 20% in those in their 6th decade; the remainder primarily in their 7th and 8th decade.
- 58% had one or more medical issues
- 13.6% pain issues
- 5.8% terminally ill

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Suicide in New Hampshire
Data from the NH Office of the Chief Medical Examiner

Living Situation at Time of Death

- 47.7% Living with Spouse
- 35% Alone
- 7% Other
- 4.5% with Child/Grandchild
- 3.8% Unknown

E. Fenner-Lukaitis, LICSW, Div Community Based Care Services, Bureau of Behavioral Health, 3/23/06

Suicide in New Hampshire
Data from the NH Office of the Chief Medical Examiner

Method/Means

- Of those who used firearms (62.5%), 41.9% had a wound to their head.
- Remaining methods included:
  - Hanging (14%)
  - Overdose (12.2%)
  - Carbon Monoxide Poisoning (3.2%)
  - Jumping, Poisoning, Drowning, Asphyxiation, etc.

Suicide in New Hampshire
Data from the NH Office of the Chief Medical Examiner

Prior Behaviors*

- 10.3% Talked about suicide
- 9.7% Made prior attempts (known to us)
- 5% Had prior treatment (known to us)
- 9% Were in treatment at time of death (known to us)

*Note: Individuals may be counted more than once.

E. Fenner-Lukaitis, LICSW, Div Community Based Care Services, Bureau of Behavioral Health, 3/23/06

Suicide in New Hampshire
Data from the NH Office of the Chief Medical Examiner

Mental Illnesses*

- 55% Depression
- 2.5% Anxiety
- 1.9% PTSD
- 1.9% Bipolar Disorder
- 1.9% NOS

*Note: Individuals may be counted more than once.

E. Fenner-Lukaitis, LICSW, Div Community Based Care Services, Bureau of Behavioral Health, 3/23/06

Suicide in New Hampshire
Data from the NH Office of the Chief Medical Examiner

Losses at Time of Death*

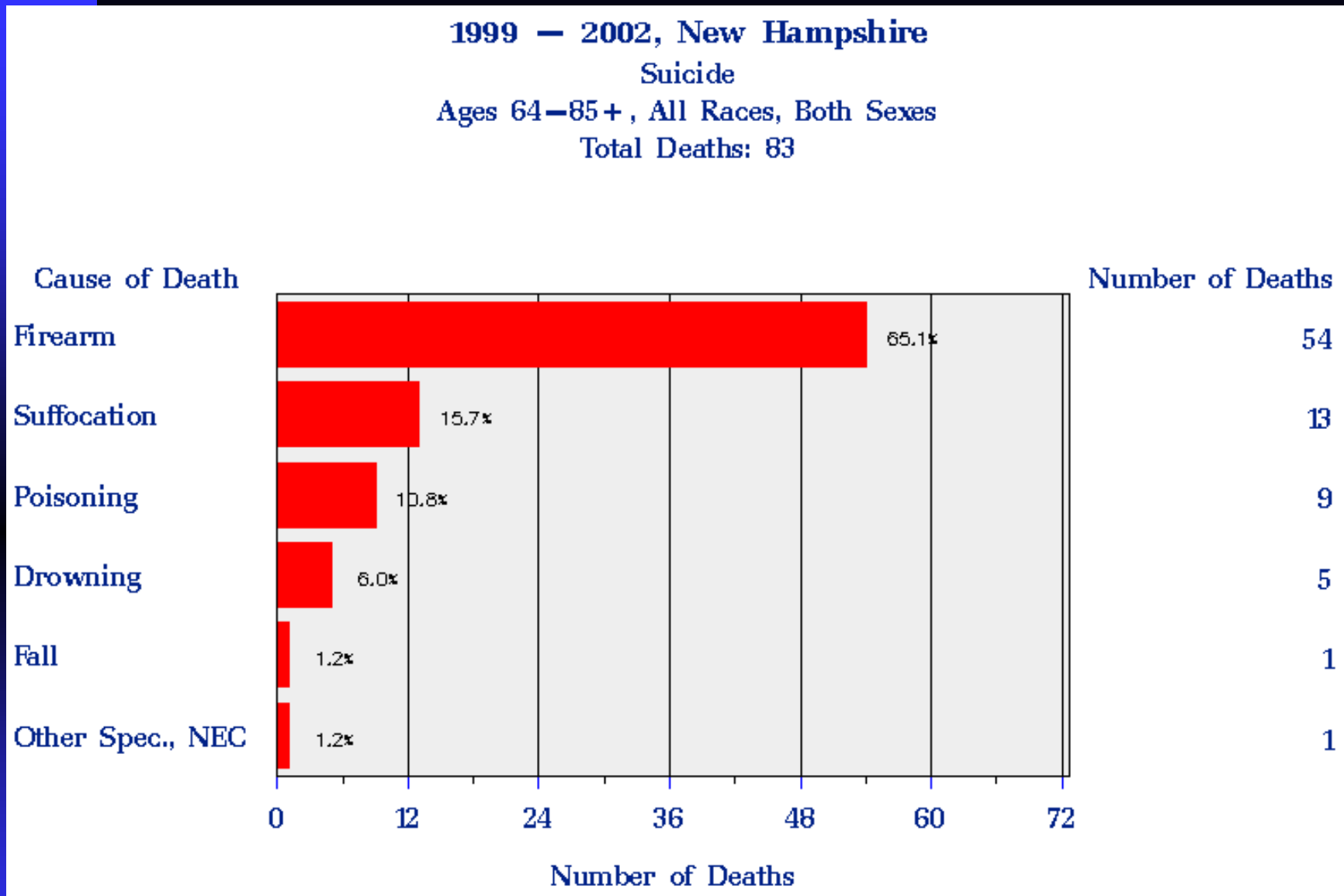
- 20% Physical decline (e.g., may have lost driving privileges)
- 19.3% Loss of productive work
- 14.8% Separation/divorce (at some point prior to death)
- Loss of spouse (9.7% at some point over a year prior to suicide; 3.2% within year of suicide)
- 3.2% Loss of housing
- 3.2% Financial stress

Facts

- Marital status
- Male vs Female
- Under-reported numbers
  - Medications
    - Overdose
    - Non-compliance
    - Alcohol
  - Starvation
  - Families avoid stigmatization
  - Protection of life insurance

Facts

- Greater lethality
- Use of more violent methods
  - Firearms
  - Hanging


1999 — 2002, New Hampshire
Suicide
Ages 64—85+, All Races, Both Sexes
Total Deaths: 83
Cause of Death
Number of Deaths
Firearm
65.1%
54
Suffocation
15.7%
13
Poisoning
10.8%
9
Drowning
6.0%
5
Fall
1.2%
1
Other Spec., NEC
1.2%
1
0
12
24
36
48
60
72
Number of Deaths
NEC means Not Elsewhere Classifiable.
WISQARS™ Produced by: Office of Statistics and Programming, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention
Data Source: National Center for Health Statistics (NCHS), National Vital Statistics System

CDC data

Despite high completion ratio

There are still some who attempt but do not succeed, thankfully

Self-harm All Injury Causes Nonfatal Injuries and Rates per 100,000 2001 - 2004, United States All Races, Both Sexes, Ages 65 to 85+ Disposition: All Cases

Year	Number of injuries	Population	Crude Rate	Number of Records
2001	5,898	35,337,728	16.69	83
2002	6,294	35,607,547	17.68	94
2003	6,775	35,919,183	18.86	95
2004	8,861	36,293,986	24.41	121

CDC data

Risk Factors

Depression

- Not a normal part of aging
- Nearly 5 million of 32 million Americans aged 65+ suffer from some form of depression

Masked Depression

- Weight loss
- Somatic focus
- Unexplained somatic complaints
- Minimization/denial of mood symptoms
- Weakness
- Lassitude
- Hopelessness/helplessness
- Anxiety, worry, rumination
- Memory complaints
- Slowed movement
- Anhedonia
- Irritability

Recurrent Major Depression associated with greatest relative risk, **however,**
Single Episode Major Depression, Dysthymia and Minor Depression also are predictive of suicide in the elderly

More Risk Factors

- Lack of social relationships
- Losses
  - Ill health
  - Financial concerns
- Substance abuse or dependence
- Poor treatment compliance

Disability

- Study of 356 men and women aged 65-95 years. Successful aging was defined as needing no assistance nor having difficulty on any of 13 activity/mobility measures plus little or no difficulty on five physical performance measures.
- 1984 predictors of 1990 successful aging with regard to behavioral and psychosocial predictors (after adjusting for all variables):
  - Absence of depression
  - Exercise (specifically walking)
  - Having close personal contacts

Strawbridge, WJ et al. (1996) Successful aging: predictors and associated activities. Am J Epidemiol.

Disability

- Study in Denmark looked at 75 year olds and 80 year olds at baseline and 1.5 years later.
- Total sample size at baseline of 1498 subjects.
- At follow-up, 38 had died, 64 chose not to participate for a follow-up sample size of 1396.
- Looked at social relations, disability, formal support, health factors.
- Overall findings: Having more extensive social relations reduce the risk of onset of disability.

K. Avlund et al./ Arch. Gerontol. Geratir. 38 (2004) 85-99.

Disability

- MacArthur study of Successful Aging. Emotional support had the strongest association with change in physical performance over 2 years.
- Total social networks have been found to be associated with a reduced risk of developing ADL disability over 9 years of follow-up.
- Medical Outcomes Study by Sherbourne et al (1992). 1402 chronically ill patients followed over 2 years. Social support associated with better physical function, especially among elderly.

Social Support and Immune Function

- Cohen et al. (1997). Looked at susceptibility of individuals to the common cold. Subjects given nasal drops containing virus.
- Those with more types of social ties were found to be less susceptible to the common cold, produced less mucus and fought infection more efficiently.
- Susceptibility to infection decreased in a dose response manner with increased diversity of the social network.

Where does this need for human connection arise?

Human Connection

- Attachment Theory
- Eriksonian Theory – Intimacy vs. Isolation (adulthood, 18-30)
- Maslow – Hierarchy of Needs – Love/Belongingness

In Summary…

Socialization:

- is a basic human need
- supports successful aging including physical function, cognitive function and immune system function

Social Isolation:

- can be unhealthy and deadly

Let’s Go Back to Risk Factors

- Lack of social relationships
- Losses
  - Ill health
  - Financial concerns
- Substance abuse or dependence
- Poor treatment compliance

- Poor impulse control
- Immediate access to a lethal method
- Previous suicide attempt

Risk Factor: Medical Illness

Juurlink et al, 2004

- Ontario residents 66+ committing suicide between 1/1/92 and 12/31/00 n=1354
- Reviewed prescription records 6 mos. prior to death, compared with matched controls
- Illnesses associated with suicide:
  - CHF, COPD, Seizure Disorder, Urinary Incontinence, Affective Disorders, Moderate/Severe pain
- Almost half visited PCP 1 week before suicide

Other studies have shown that 70-75% of elderly committing suicide have visited their PCP within 1 month of their suicide

90% of older adults had a knowledgeable informant

Suicide Predictors: Old Elderly

Waern et al, 2003, Sweden

- 85 consecutive suicides / matched controls
- 38 suicides in 75+ y.o. ; 47 in 65-74 y.o.
- Life events and mental/physical health
- Family conflict, serious physical illness, loneliness and depression found to be associated with suicide in older group.
- Family discord strong predictor in both
- Old elderly less likely to receive depression treatment

Elderly give fewer warning signs,
More violent than younger counterparts, and
Show greater resolve in completion of suicide

"While physical illness and functional impairment are associated with suicide in older adults, much if not all of the risk associated with physical health factors is mediated by their relationship with affective disorder."

Conwell et al, 2002

Ten Commonalities of Suicide

I. The common purpose of suicide is to seek a solution.

II. The common goal of suicide is cessation of consciousness

III. The common stimulus in suicide is intolerable psychological pain

IV. The common stressor in suicide is frustrated psychological needs.

V. The common emotion in suicide is hopelessness-helplessness

Edwin Shneidman, J Geriatric Psychiatry, 1991; 24(2): 153-174

Ten Commonalities of Suicide

VI. The common cognitive state in suicide is ambivalence

VII. The common perceptual state in suicide is constriction

VIII. The common action in suicide is egression

IX. The common interpersonal act in suicide is communication of intention

X. The common consistency in suicide is with life-long coping patterns

Edwin Shneidman, J Geriatric Psychiatry, 1991; 24(2): 153-174

Assessment

- Take threats seriously
- Explore “passive” statements (“I wish I wouldn’t wake up tomorrow”) as well as “active” statements
- Assess for Indirect Self-Destructive Behaviors
  - Noncompliance with treatment
    - Refusing medications
  - Refusing to eat

- Evaluate support systems
- Assess substance use/abuse
- Assess feelings
- Ask about suicide plans

Direct Questions

- Are you feeling so down you see no point in going on?
- Are you thinking about dying?
- Are you thinking about hurting yourself?
- Have you ever thought about killing yourself?

Direct Questions

- How often have you had these thoughts?
- Have you thought about how you would do it?
- Do you know when you would do it?
- Do you have the means to do it?
- What has kept you from carrying out your plan thus far?

Note:

Asking someone if they are thinking of suicide, won't push them towards it. Instead, it may decrease their risk by giving them an opportunity to talk and be heard.

Suicide “clues”

- Verbal
  - Threatening suicide
  - Saying goodbye
  - Expressing hopelessness or worthlessness

Suicide “clues”

- Behavioral
  - Previous suicide attempts
  - Giving things away of value
  - Increased self-destructive behaviors
  - Isolation

Suicide “clues”

- Situational
  - Changes or losses occurring during the aging process – increase risk
    - Recent move
    - Death of spouse, child, friend
    - Diagnosis of terminal illness

Suicide “clues”

- Syndromatic – Psychological Syndromes
  - Depression and anxiety
  - Tension, agitation, guilt & dependency
  - Rigidity, impulsiveness & isolation
  - Changes in eating and sleeping
  - Sudden recovery from deep depression

Interventions

PROSPECT

Brown et al, 2001

Prevention of Suicide in Primary Care Elderly Collaborative Trial

Goal:

Determine if placement of a depression health specialist in PCP offices will positively impact rates of depression, hopelessness and suicidal ideation in elderly primary care patients with major and minor depression

Prospect Study - Guidelines

- Be very attentive.
  - Take SI seriously.
  - Attentive listening can dispel stigma & fear that SI is shameful
- Remain calm and non-threatened

- Give patient space/time to vent
  - Patients feel validation from empathic listening
- Emphasize team approach
  - “We have to find a way for you to get some relief when you feel depressed.”
- Be comfortable with word, “suicide”

Prospect Study – Ongoing Management

- Inquire re: frequency/content of SI
- Explore problem that led to crisis
- Ask about arguments for/against suicide
  - Generate a list of as many reasons for living as possible. Generate hope
- Evaluate access to means of suicide
- Explain depression – prognosis & treatment

- Develop formal contract *
  (include family if necessary/possible)
  - Agreement to not self harm
  - Agreement to contact MH provider if impulses are too strong
  - Agreement for MH provider to be available
  - Contact phone numbers for MH provider
  - Both people sign contract

**A contract gives no guarantee*

- Advise discontinuation of alcohol/illicit drug use
  - Increases impulsivity
  - Decreases judgment
  - Worsens depression
- See at least weekly while SI is present
- Avoid writing prescription for >1 week
- Educate family members how to respond (when family is involved)

Hospitalization may be necessary

- High levels of unresolved stress
- Loss of impulse control
- Lack of supportive social support network
- Seriousness of intent
- Potential for lethality
- Level of patient cooperation
- Is patient alone?

www.guideline.gov

If hospitalization is needed

- Call 911
- Do not allow patient to drive self
- Family should not, generally, drive patient

www.guideline.gov

"Contrary to strongly held mid-20th century views, suicide now is regarded as an important – and preventable – public health problem, one that has received increasing national and international focus during the years."

Moscicki & Caine

Center for Elderly Suicide Prevention and Grief Counseling (CESP) *

- 24-hour Friendship Line for the elderly
- Outreach calls to older adults
- Regularly scheduled supportive home visits
- Grief support
- Two-day workshops on suicide intervention for volunteers and the community

*http://www.gioa.org/programs/cesp/cesp.html

CESP ~ Friendship Line

- Seniors, 60 and over, can call when they are depressed, isolated, grieving, suicidal, going through a difficult time, in an abusive situation, or are lonely and want to talk to someone.

CESP ~ Outreach services

- Seniors 60 and over who live in San Francisco.
- Regularly scheduled telephone calls (ranging from daily to once a week) for emotional support, medication reminders, or safety checks.
- Weekly in-home supportive visits.

Yuri town, Japan

- Community based prevention program
- Baseline: 8 years – 1987 to 1994
- Implementation: 8 years – 1995-2002
- Intervention cohort vs. Reference cohort

- Goals
  - Increase acquaintances
  - Develop closer neighbor relationships
  - Increase life fulfillment
- Provided group activity
  - Volunteer services
  - Indoor activities
  - Physical activities

- Group activities held every 2 to 4 monts
- Psychoeducation
  - 1-2 times per year

Outcome

- Risk of suicide in elderly women was reduced by 76%
- No change in elderly males

QPR

Question

Persuade

Refer

QPR Institute – Spokane, WA

http://www.qprinstitute.com

Basic Assumptions Regarding Elders Most at Risk:

- Tend not to self-refer for help
- Tend to be treatment resistant
- Frequently abuse drugs and/or alcohol
- Conceal their level of despair
- Minimize the severity of their problems
- Go undetected by the “system”
- Go untreated

QPR Institute – Spokane, WA

Likely Reasons for Not Seeking help:

- Pervasive feelings of shame
- Suspicion of do-gooders
- Fear of hospitalization or loss of control
- Failing memory, mobility
- Fear of becoming a burden
- Onset of clinical depression or dementia
- Lack of social support (to help navigate system)

QPR Institute -- Model

Three Legs of the Stool:

1. Mobile Mental Health Team – to care for elderly in their homes
   - Created staff education and training programs in geriatric psychology and psychiatry
2. Primary Care Physicians to deliver care (as many elderly had outlived their PCPs)
   - Approached U of W Family Medicine Residency for assistance

QPR Institute -- Model

Three Legs of the Stool:

3. Public Health Model -- Detection
   - Eyes and Ears of Community-Based people
     - Frequent contact with elders as part of routine work
     - Would be willing to be trained to recognize s/s that may indicate an elderly person in need of help

QPR Institute -- Gatekeepers

- Training was no more than 90 minutes
- Available at employer's convenience
- Repeatable at any time, upon request
- Available at no charge
- Agency assumed all medical-legal liability for services rendered
- Every referral made, resulted in feedback to the gatekeeper – recognition for "good works" and rewards for employee and employer

QPR Institute -- Training

- Problems with personal appearance (unshaven, dirty clothes, body odors, unkempt hair)
- Conditions of the home (poor repair, calendar on wrong month, little or no food, strong odors, too many cats, garbage, walks covered with snow)
- Mental and emotional – confusion, disorientation, inapprop responses, forgetfulness, repetitivenss, distrust, fear of strangers

QPR Institute -- Training

- Complaints of not eating
- Problems in sleeping
- Evidence of alcohol use (bottles piling up)
- Anger, irritability, hostility
- Appears sad, blue, talking of loss
- Physical losses/complaint of hearing loss
- Mobility losses? Homebound now?

QPR Institute -- Training

- Look for personality changes – isolated, withdrawn, suspicious, angry – different from earlier contact?
- Economic problems? Can't pay bills? Overpays or tries to?
- Warning signs of suicide…multiple losses? Suicidal communications – giving away personal possessions?

QPR Institute – Gatekeeper Action

Identify a Concern

Call Clinician/Agency

Name, location and concerns

Clinician takes it from there…

QPR Institute – Gatekeepers?

- property appraisers
- apartment managers
- telephone company personnel
- police and sheriff officers
- ambulance personnel
- fire fighters
- Ministers
- telephone company staff
- utilities personnel
- postal carriers
- Pharmacists
- bank tellers
- meter readers
- power company billing staff
- fuel oil dealers
- anyone with frequent contact with at-risk elderly

"There is no suicide (except possibly jumping) that does not involve the hand. In a figurative sense, suicide is always held within the hand of the individual (which is our way of saying that it is within the mind). But also, in this figurative way, the prevention of suicide is clearly in the hands of others. I am thinking not only of helping hands but even more of alert minds and compassionate hearts that are attuned to signals of lethally oriented distress in a needful fellow human being, of whatever age."

Edwin Shneidman, J Geriatric Psychiatry, 1991; 24(2): 153-174